PROPOSED REPORT TO THE COMMITTEE ON THE BUDGET FROM THE COMMITTEE ON VETERANS' AFFAIRS SUBMITTED PURSUANT TO SECTION 301 OF THE CONGRESSIONAL BUDGET ACT OF 1974 ON THE BUDGET PROPOSED FOR FISCAL YEAR 2004

BACKGROUND AND COMMITTEE RECOMMENDATIONS

The Committee on Veterans' Affairs, after careful consideration of the budget for fiscal year 2004 proposed by the Administration for the Department of Veterans Affairs (VA), believes that Congress should act to close the recurring gap between appropriated funding and the demand by eligible veterans for VA health care. Therefore, the Committee recommends a substantial increase in veterans' health care funding for fiscal year 2004. Further, the Committee recommends that Congress adopt a new, fiscally sound finance system that would provide guaranteed funding for VA health care programs.

DEPARTMENT OF VETERANS AFFAIRS

Veterans Health Administration

The Status of VA Health Care. – Beginning in the mid-1990s, the Department of Veterans Affairs accelerated internal reforms of its health care delivery system for veterans, greatly emphasizing primary and managed care, while expanding sites of clinical service. Today, VA health care is widely available to millions of veterans in 1,300 locations, ranging from major urban academic medical centers to rural storefront clinics. VA health care is recognized for its world-class patient safety program and provides veterans a measurable advantage in quality of care. As provided by law, VA manages veterans' access to care through a formal enrollment system. Through outreach VA has enrolled nearly seven million veterans, about five million of whom are regular patients.

While the number of veterans enrolled in VA medical care has increased dramatically, appropriated funding is not keeping pace with the growth in enrollment or the increased needs of elderly veterans. Further, much of VA's capital infrastructure (hospitals and clinics) is outdated or not receiving adequate maintenance. Many VA health care structures are subject to severe seismic risk and some, in fact, have been damaged by earthquakes in recent years. Some obsolescent facilities need complete replacement.

In July 2002, VA reported to Congress that it estimated that 310,000 veterans were waiting more than six months for initial appointments. By December 2002, that number had been reduced to 236,000, but two-thirds of these were new enrollees, not respondents to the initial data review from July.

The Secretary of Veterans Affairs, the Honorable Anthony J. Principi, on February 11, 2003, presented the VA's budget request for fiscal year 2004 to the Committee. In his testimony, the Secretary observed: "[t]he demand for VA health care has risen dramatically in recent years. From 1996 to 2002, the number of patients to whom we provided health care grew

by 54 percent. Among veterans in Priority Groups 7 and 8 alone, the number treated in 2002 was about 11 times greater than it was in 1996."

The Department has confirmed to the Committee that in the current fiscal year, it projects a shortfall in resources of $1.9 billion to meet the anticipated needs for medical services of those already enrolled. At the Committee's hearing on the state of the VA health care system on January 29, 2003, the Under Secretary for Health, the Honorable Robert H. Roswell, testified that to adequately meet the needs of VA's core constituency of service-disabled and poor veterans, the Veterans Health Administration would require annual budgetary increases of 13 to 14 percent. The Department received a record health care funding increase of 11 percent from the omnibus appropriations bill signed by the President on February 20, 2003, Public Law 108-7. This increase, however, did not address the reported $1.9 billion shortfall.

The FY 2004 budget proposes closing 5,000 VA nursing home beds at a time when older veterans' needs for nursing home care are growing. VA would substitute non-institutional alternatives, as well as state and community nursing home beds for these VA nursing home beds, but does not request sufficient resources to match the level of capability eliminated by removing these beds from service. VA also proposes that Congress double VA's prescription copayment for some veterans. The Secretary of Veterans Affairs already has the authority to increase copayments when necessary without intervening action by Congress, provided the copayment does not exceed the actual cost for these drugs. In February 2002, VA more than trebled the prescription copayment amount. The Committee does not recommend additional increases.

The Secretary proposes that Congress impose an annual enrollment fee of $250 on Category 7 and 8 veterans. The Committee is concerned about ramifications of such a policy and is opposed to its enactment as a solution to VA's recurring financial problems. Other alternatives to resolving VA's funding deficits should be exhausted before imposing this additional cost on veterans. Proposals designed to discourage veterans' use of services could prove unnecessary, for example, with passage of a meaningful drug benefit. The Committee recommends an additional $773 million to account for needs associated with retention of nursing home beds, expansion of alternative programs and maintaining veterans' access to care.

The Committee notes that the Secretary of Veterans Affairs has announced an agreement in principle with the Secretary of Health and Human Services to execute an agreement under the Medicare Part C program so that VA facilities with available capacities may participate in a "VA+Choice" managed care plan for a small number of Priority 8 veterans now temporarily excluded from direct enrollment in VA health care. Also, over a quarter million veterans currently enrolled in VA care are simultaneously enrolled participants in the military TRICARE program; the VA should actively seek greater cooperation from the Department of Defense in coordinating benefits for military retirees who are enrolled as veterans in the VA health care system.

If a private or other public health insurance plan covers a veteran, whether through a private employer or the Federal government, VA should have access to that information. The Committee supports the Secretary's proposal to make accurate insurance disclosure a

requirement and expects to report legislation providing this authority along with other measures, such as deeming VA a preferred provider for purposes of receiving payment from managed care organizations. These new authorities would aid VA's collections program.

Inflation. – The medical care component of the Consumer Price Index (CPI) continues to escalate, outpacing all other items in the CPI for the past seven years. The Bureau of Labor Statistics (BLS) released inflation rate data in December 2002 that showed the overall health care inflation rate was 5 percent. Within that level, hospital care inflation was the highest single component at 10.2 percent, followed by prescription drugs and medical supplies at 6 percent. An experimental price index Congress directed BLS to develop also reveals that persons 65 years of age and over are spending more than twice as much on health care as the total population. During the Committee hearing on January 29, 2003, Dr. Roswell testified as follows:

> "One of the things that we have determined is that in a typical year, our expenses increase 6 to 7 percent by new enrollment in Priorities 1 through 7. In addition to that [enrollment growth], increased utilization, because the veteran population ages, and health care expenditures and health care utilization increase. With every increasing year of age, particularly in an elderly population, we have another 2 to 3 percent incremental cost every year. So a 7 percent increase associated with enrollment in our highest priority groups, coupled with another 2 to 3 percent of increased utilization costs, coupled with a conservatively estimated health care inflation rate of 4.5 or 5 percent, yields a 13 or 14 percent per year increase in the money available to take care of just our core population of veterans."

Rising Pharmaceutical Costs. – VA expects to spend about $4.4 billion this year on its pharmaceutical programs. VA's budget for prescription drugs has nearly doubled over the past three years and, at the current rate of growth, will exceed $7 billion by the end of fiscal year 2008. A budget growth of such magnitude stems from both higher utilization of the program by veterans and increased use of new drugs. From December 2000 to December 2002, the Veterans Health Administration reported that enrolled veterans increased from 4.7 million to 6.7 million, with about 4.7 million expected to be active consumers of VA health care services. VA should request adequate funding to ensure that it remains capable of providing state of the art pharmaceutical drug treatment.

An assumed inflation rate of 5 percent in VA health care from the beginning of fiscal year 2003 would mean that about $1.2 billion of its fiscal year 2003 appropriation of $23.9 billion is being consumed by the general erosion of purchasing power. VA has estimated that it would require more than $30 billion to provide current services in fiscal year 2004. The effects of inflation, payroll, increased workloads, pharmaceutical services, and new emergency preparedness programs require a $3.8 billion increase over the FY 2003 appropriation just to maintain services. These costs must be considered in developing the budget resolution.

Capacity and Demand for Long-term Care Services. – Public Law 106-117, the Veterans Millennium Health Care and Benefits Act of 1999, expanded VA's mission to provide and maintain specialized capacities to care for aging veterans. The Committee has been in regular

communication with the Secretary concerning a noted decline in VA nursing home beds (approximately 2,000). On May 8, 2002 the Secretary made a commitment to restore these beds to their prior level, provided that Congress appropriates an increase in VA's medical care appropriation for fiscal year 2003. In the omnibus appropriation approved by Congress on February 13, 2003, VA received $1.1 billion more than what was requested by the President for the period.

The Committee is disappointed by the Secretary's proposal in this budget to close thousands of additional VA nursing home beds. VA's own long-term care model, based on the medical needs of its users, indicated a need for 17,000 new nursing home beds by 2020. The Committee does not believe that VA can replace 5,000 nursing home beds with outpatient programs for elderly, chronically ill veterans.

VA has never fulfilled the promise of its landmark study in 1984, *Caring for the Older Veteran*. That study recommended large increases in both inpatient and alternative programs, such as respite, hospice, adult-day and home-based care, so that VA could approach the needs of World War II veterans with meaningful, health and end-of-life care programs, on both institutional and non-institutional bases. This has not been achieved.

In order to aid the Department in maintaining its current nursing home bed level, the Committee recommends that VA's budget request be augmented by an additional $297 million. Furthermore, VA should launch effective alternatives in long-term care and reopen long-term care nursing beds which have been closed.

Health Care for World War II Filipino Veterans. – Last year, the House approved legislation to authorize VA to provide health care to certain Filipino World War II veterans now legal residents or citizens of United States. The Administration supported this provision and the Secretary stated that VA would absorb the $12 million estimated cost of implementation in the Departments budget. The Committee recommends an additional $12 million to support this proposal.

Mental Health Programs for Disabled Veterans. – Over the past five years, the Department has shifted resources and programs away from institutional mental health care. The Committee supported this reallocation (see House Committee Print No. 5, 106th Congress, First Session, March 16, 1999). However, as VA planned new community-based intensive case management programs, it was understood that sufficient resources would be preserved to provide an appropriate level of care for VA's chronically mentally ill patients.

The VA Advisory Committee on Seriously Mentally Ill Veterans estimates the shift in resources from mental health programs may be as much as $600 million. VA has dramatically expanded its primary care clinics. While the Committee certainly supports the primary care clinics, VA should partially restore lost support for mentally ill veterans. Again this year the budget request does not address this need. The VA Program Evaluation Resource Center maintains a registry of veterans suffering with psychosis and bipolar disorder that contains 200,000 individuals. These veterans cannot be sustained medically without intensive efforts. Due to the nature of their illnesses, most cannot speak for themselves. Accordingly, the Committee recommends a number of funding adjustments in the following areas:

1. *Mental health intensive case management teams* – The Committee understands that VA presently operates about 50 intensive case management teams assigned to aftercare of VA patients with serious and chronic mental illness. Some of these teams that already had a minimal staffing complement have recently suffered reductions in staff. A fully functioning team's annual average direct cost (primarily in staffing) is approximately $400,000. The Committee recommends an additional $40 million for fiscal year 2004 to fund 30 additional teams for a total of 80 Mental Health Care Intensive Care Management teams to provide vulnerable veterans better follow-up care and improved coordination of community based services.

2. *Mental health in community primary care* – The Department operates approximately 650 community based outpatient clinics nationwide. When VA made the decision to provide better access to community-based primary care, it did not sufficiently provide for mental health needs in these clinics. Approximately half of these facilities offer dedicated mental health services, but the remaining sites do not. The addition of qualified mental health staff to support effective professional services in these settings is a way to ensure that mental health care becomes more accessible and convenient. Adding a small cadre of mental health professionals at approximately 200 locations (according to their need) would provide a more complete service in VA community-based clinics. A $40 million enhancement to mental health capacity would also give VA better options to care for not only the de-institutionalized chronically mentally ill, but also to provide new services to veterans with acute mental health needs who may not otherwise receive adequate care.

3. *Substance-abuse programs* – VA Currently cares for 130,000 veterans with substance abuse problems. Over the past decade, VA shifted its drug treatment programs from residential care to ambulatory-based programs. VA has acknowledged in its report under section 1706 of Title 38, United States Code, that capacity in the substance-abuse disorder programs is declining. The Committee believes these programs should be restored. Opioid-substitution programs are insufficiently available in VA facilities and in some metropolitan areas do not provide enough care to meet the needs of the veteran population. The Committee recommends $20 million in additional funds to address these shortcomings.

Medical Care Collections Fund. – VA is authorized to bill health care insurers for covered non-service-connected care provided to veterans. The Department projects medical care collections for 2004 to be $2.1 billion. This would be the largest one-year increase in collections in the program since Congress authorized it in 1986 – 32 percent above the estimated end-of-year collections for 2003. The Department is attempting to achieve this remarkable goal by implementing a revenue cycle improvement plan and collecting better, verifiable insurance information sooner in the process of patient care. VA also is pilot testing a business plan to reconfigure the revenue collection program with contracted efforts and commercial collections systems using standard practices.

The Committee supports the Department's efforts at improving performance in first- and third-party collections, but the Committee remains skeptical that VA can achieve all it promises in fiscal year 2004. If VA fails to achieve its goal of such a significant one-year increase, veterans will be denied care to the extent of that failure. The Committee is unwilling to assume

VA will be successful in increasing collections as promised. Assuming the Department can accomplish a 10 percent increase in collections in fiscal year 2004 over the current estimate for this year, the Committee recommends that $363 million be restored to Medical Care to account for the difference between VA's budget level and the practical effect of its actions.

Management Improvements and Efficiencies. – The Department's 2004 budget proposes to achieve management savings of $950 million, three times the level of savings reported for fiscal year 2003, from management efficiencies and improvements, and by deferring the procurement of medical equipment to the future. VA's plans include implementing a competitive out-sourcing plan, reforming the health care procurement process, increasing employee productivity, increasing health resources sharing with the Department of Defense, and continuing the trend of shifting patients from inpatient to outpatient levels of care.

The Committee concludes that VA will be able to achieve only about a quarter of the management savings it has proposed in this budget. Therefore, the Committee recommends an additional $700 million for veterans' medical care.

Homelessness Among Veterans. – With the passage of the Homeless Veterans Comprehensive Assistance Act of 2001, the Committee enunciated a goal of ending chronic homelessness in the veteran population within a decade. More than a year since enactment of this law, the Committee is not satisfied with VA's responsiveness to the mandates of this Act. Among some of the most effective activities that need additional funding are VA homeless domiciliaries; VA's grant and per diem program for community providers; and the so-called "Health Care for Homeless Vets' initiative." VA also funds several programs in mental health and coordinates with other Federal agencies (principally the Departments of Housing and Urban Development, and Labor) to address veterans' homelessness. VA has yet to implement a prison and institutional outreach-transition initiative and a special needs authority provided in the Act.

The Department has made a $5 million commitment to provide health care services and case management in a VA-HUD-HHS joint venture that would open 300-400 new beds in sites yet to be announced. VA is prepared to commit $10 million to provide dental services to homeless veterans as authorized in the Act. The Department has not made a transitional housing loan as authorized by 1998 legislation despite a commitment to do so. The Committee rejects the VA proposal that Congress convert the transitional housing loan program to a grant program.

The Act authorized funding of $75 million for the several in-house homeless assistance programs for fiscal year 2003, but VA is requesting no funding in its budget. Also, the Act authorized $5 million for homeless domiciliaries in fiscal year 2003, and an additional $5 million in 2004. VA made no request for these funds. The Committee recommends that $75 million be added to the VA's budget to address the still unmet needs of about one-quarter million homeless veterans.

Medical and Prosthetic Research. – The Department carries out an extensive array of research and development as a complement to its affiliations with medical and allied health professional schools and colleges nationwide. While these programs are specifically targeted to the needs of veterans, VA research has defined new standards of care that benefit all Americans. Among the

major emphases of the program are aging, chronic diseases, mental illnesses, substance-use disorders, sensory losses, and trauma-related illnesses. VA's research programs are internationally recognized and have made important contributions in virtually every arena of medicine, health, and health systems.

The Secretary has requested a 2004 budget for VA Medical and Prosthetic Research of $408 million, an increase of $8 million or 2 percent over the fiscal year 2003 level. The Committee strongly supports an increase in the research account to $460 million (15%) in 2004, as recommended by both the *Independent Budget* as well as the *Friends of VA Research* coalitions. The Committee believes this additional funding is needed in VA's research programs to keep pace with funding developments in the Federal biomedical research community. A 16 percent funding increase was provided in the 2003 omnibus appropriations bill for the National Institutes of Health. Additional funding of $52 million in VA biomedical research in fiscal year 2004 would provide coverage for inflation and permit a small program expansion.

Emergency Preparedness in Bio-Terrorism. – The Department of Veterans Affairs Emergency Preparedness Act of 2002 mandated VA to establish four national emergency preparedness centers and an educational curriculum for medical students and professionals for response to weapons of mass destruction. The Act authorized $20 million per year for the support of the centers. Due to unavailability of funds, the Department has yet to proceed with establishment of the centers. These centers are critical to enable VA to aid the Department of Defense and other Federal agencies to contend with the war on terrorism, and even more importantly, to aid VA in preparing itself to deal with the effects of the use of weapons of mass destruction. The Committee urges the Committee on the Budget to include $20 million to support the establishment of these new bio-terrorism research centers. The Act also authorized the establishment of an education program to be carried out through VA. The education and training curriculum would include a program to teach current and future health care professionals how to diagnose and treat casualties who have been exposed to chemical, biological, or radiological agents. The Committee also urges the Committee on the Budget to include an additional $5 million to support the requirement.

Medical Administration and Miscellaneous Operating Expenses. – For national program administration, the Secretary proposed an increase in the Medical Administration and Miscellaneous Operating Expenses (MAMOE) account of $9.4 million in fiscal year 2004. The budget requests a total of $87.5 million in MAMOE to provide improved corporate leadership and support to VHA. Specifically, by providing VHA a basis to increase staffing in national program administration from the fiscal year 2003 estimated level of 545 to a planned 588, this increase will have an impact on the development and implementation of policies, plans, and broad program activities. The increased funds are intended to help complete the restructuring of the Office of the Under Secretary for Health which began in 2002. Part of this restructuring is focused on the Capital Assets Realignment for Enhanced Services (CARES) process and the creation of a new Deputy Under Secretary for Health Policy, whose purpose will be to better coordinate federal health care benefits between various agencies, and to enhance the prospects for VA-DOD sharing. The Committee supports $87.5 million as requested for MAMOE.

CARES and the Continuing Needs of Veterans. – VA is continuing its initiative to identify the most effective and efficient use of its infrastructure in health care delivery to veterans. The

Committee held a number of hearings during the 107th and earlier Congresses dealing with VA's capital assets. VA hospitals were primarily built or converted after World War II to rehabilitate and care for wounded, sick and traumatized soldiers, sailors, airmen, and marines. For the past thirty years VA has gradually changed its health care approach from an institutional provider of physical medicine and rehabilitation, long-term psychiatry, and restorative care to that of an outpatient and acute primary care provider to serve an older population with chronic illnesses. The capital infrastructure built for its previous approach does not easily lend itself to VA's new delivery model.

Even though VA's CARES process will take several years to complete, the Committee strongly believes that VA's most pressing capital infrastructure needs must be addressed. Due to the CARES process, in recent years VA has proposed few construction projects.

Outside consultants and VA's own reports show a growing need and rising backlog of major and minor projects. For example, a 1998 Price Waterhouse report suggested VA, in proportion to the value of its $35 billion infrastructure, should be investing in the range of $700 million to $1.4 billion annually on replacement and modernization projects. A second consultant report disclosed dozens of VA patient care buildings at the highest level of risk for earthquake damage or even collapse. Another report revealed $57 million in needed projects to protect women's privacy in VA health facilities.

Major Construction Projects. – In the 107th Congress, the Committee authorized nearly $800 million in major medical facility construction needs, but little of this funding was appropriated. Last year, the Department advised Congress of its major construction priorities, as follows:

1. *Palo Alto, CA*: This project would include seismic corrections, correction of patient privacy deficiencies, correction of fire safety deficiencies, and functional improvements for the Mental Illness Research, Education and Clinical Center.

2. C*leveland, OH*: This project would include the replacement of all mechanical, electrical, and architectural systems installed in this facility built in 1961.

3. *San Francisco, CA*: This project would seismically upgrade the main inpatient building at the San Francisco VA Medical Center.

4. *Anchorage, AK*: This project would consolidate the Alaska Veterans Affairs Health Care System and Regional Office at Elmendorf Air Force Base, Alaska.

5. *West Los Angeles, CA*: The upgrade of Building 500 would strengthen braced frames below the second floor, strengthen collector plate connections to the braced frames, and add new collector plates to transfer loads in the central core area to the braced frames located at the wings.

6. *West Haven, CT*: This project would renovate three inpatient wards to correct for patient privacy inadequacies as well as consolidate associated support services.

7. *Long Beach, CA*: Building 7 of the VA Long Beach Medical Center would be

seismically upgraded and retrofitted.

8. *Palo Alto, CA*: Renovations would include seismic corrections, correction of fire safety deficiencies, and functional laboratory improvements in areas formerly occupied by inpatient psychiatric wards. Building 205, Menlo Park campus, would be demolished. Most research personnel would be relocated.

9. *Tampa, FL*: This project would relocate three Spinal Cord Injury (SCI) inpatient wards and ancillary support functions to a new SCI building.

10. *VISN 4 (PA, WV, NJ, DE, OH)*: This multi-facility project would renovate and expand outpatient clinics at seven different medical centers. Six of the eight projects would renovate and expand primary and specialty care clinic areas. The other two projects would expand outpatient ambulatory surgery and outpatient day programs.

11. *Beckley, WV*: This project would consist of design and construction of a nursing home care unit with 120 beds.

12. *Lebanon, PA*: This project would reconfigure two floors at the VAMC which is currently unfit to house inpatients. A new elevator shaft and entrance would be built to meet the needs of the patients.

13. *San Diego, CA*: This project would seismically strengthen the Medical Center by adding two new exterior unbonded braced frames at the end of each building wing, replacing the braces in all of the existing braced frames with new unbonded braces, and adding new collector elements.

14. *Hines, IL*: A blind rehabilitation center (authorized and appropriated in fiscal year 2002) would be relocated and modernized.

15. *San Juan, PR*: The air conditioning would be repaired and overhauled in conjunction with asbestos abatement and further seismic protections in three areas in the existing basement, first, and second floors.

16. *VISN 6 (WV, VA, NC)*: This multi-facility project would renovate five VAMCs' Mental Health and Spinal Cord Injury/Dysfunction Units. The project includes privacy improvements, hazardous materials abatement, window replacement, and HVAC and utilities upgrading.

17. V*ISN 4 (PA, WV, NJ, DE, OH)*: This multi-facility, VISN-wide project would renovate and upgrade seven major VA medical centers for patient safety and patient/employee welfare.

18. A*tlanta, GA*: The renovations would correct patient privacy issues, improve staff efficiencies, improve the functional layout, and meet ADA requirements and female patient issues.

19. *Tampa, FL*: This project would provide approximately 1,170 additional parking spaces for the Tampa VA Medical Center.

20. *Washington, DC*: This project would allow for three new clinics to improve patient flow between primary care and specialty care clinics.

While the House passed an authorization measure supporting the completion of many of these high-priority projects, only the Hines, IL project on the above list received appropriations in fiscal year 2002. No funds for any of the other projects were appropriated in fiscal year 2003.

The Committee understands that the sale of the underutilized VA Lakeside hospital in Chicago was expected to be a direct source of funding to improve the West Side VA facility as a key acute inpatient facility for the veterans of Chicago. VA indicates in the budget that CARES will provide the funding for the project which is now estimated at $98.5 million, considerably less than the previous estimate.

The Colorado University School of Medicine plans a major relocation of all its facilities to the site of the closed FitzSimons Army Hospital. VA is considering whether to recommend replacement of the Denver VA Medical Center, a 50-year-old structure now co-located with the Colorado medical school as a part of that relocation. These two projects alone, the West Side tower and the new Denver VA Medical Center are estimated to cost nearly $500 million.

In addition, there are many other worthy projects high on VA's established priority list that lack funds. Many are medical centers that will not be affected significantly by CARES and that are needed to continue providing good health care to veterans. The Committee will further explore these needs and will recommend projects to meet them. Consequently, the Committee recommends an additional amount of $500 million for the major medical facilities construction account in fiscal year 2004.

State Home Grants Programs. – In 47 states, 114 homes for veterans provide nursing, domiciliary care, and adult day care to over 21,300 veterans whose care is coordinated with the Department of Veterans Affairs. States commit to pay 35 percent of the construction costs of projects for state home facilities, and to bear most of the cost of facilities operations and health care that exceeds amounts contributed by VA. Fiscal year 2003 applications totaling $287 million for new construction and renovation grants to state veterans homes are pending in the Department. A new round of requests will be solicited in April 2003 for fiscal year 2004 awards.

Congress revised the state home program in Public Law 106-117 to provide a higher priority for critically needed renovations in existing state homes, especially those projects involving fire and life safety improvements. Prior to enactment of P.L. 106-117, these long-delayed projects were given a lower priority for funding than grants for constructing new state home beds. Although VA has implemented the provisions of the Act affecting the ranking criteria for funding projects, renovation projects remain 63 percent of the overall backlog of unfunded projects. The budget requests $102 million to support the grant program, a two percent increase over the fiscal year 2003 appropriated level. The Committee recommends additional funding of $30 million to support a more adequate VA response to the growing

demand for long-term care facilities and to modernize and renovate existing facilities in the states' inventories. Provision of these funds will support the establishment of approximately 360 new nursing home and domiciliary beds in state veterans' homes.

Veterans Benefits Administration

Compensation and Pension Service. – The ability of VA to provide accurate, timely and quality benefits delivery is dependent on a number of factors, including an adequate number of properly trained staff, effective business process and computer modernization initiatives, accountability measures, inter-departmental cooperation between the various VA administrations and military service departments, including the National Personnel Records Center and the Center for Unit Records Research, and assistance from the veterans service organizations. Entitlement benefits are provided to 2.5 million veterans, more than 316,000 survivors, and 1,115 children.

The President is requesting $29.9 billion and 8,586 FTEE to support the compensation and pension entitlement benefits programs. This represents a $3.4 billion dollar increase over the enacted fiscal year 2002 level, but a decrease of 190 FTEE is also proposed. The Committee is concerned that a decrease in FTEE could detract from continued improvements in claims processing. The Committee notes that a number of VBA employees have been called to active military service and that additional activations may adversely impact claims processing.

Both the President and the Secretary have made timeliness and quality in claims adjudication a top priority, and have set a goal of adjudicating claims within 100 days by the summer of 2003. In December 2002, the average days pending for a rating-related claim were 168, reduced from a high of 203 days in January 2002. Additionally, the reported national accuracy rate increased from 78 percent in 2001 to 80 percent in fiscal year 2002, with a target of 90 percent in 2004. VBA decreased its claims workload from 345,516 rating-related claims at the end of September 2002 to 328,468 as of December 2002.

In October 2001, the VA Claims Processing Task Force made 34 recommendations to improve claims processing. Of the 66 action items, 38 have been implemented – 28 completely and 10 which are being monitored to ensure that the goals of the recommendations are being met. The Committee recommends $12 million for VBA to implement the medium and long-term recommendations, to include hiring nurses and other medically-trained individuals, including veterans who have worked as medical corpsmen or in similar military specialties, to work on compensation and pension claims, to establish a more permanent claims adjudication training cadre, and to out-base rating specialists at 70 of the largest VA medical centers.

VBA Staffing for all Business Lines. – The Committee commends VBA for its recent improvements in claims adjudication; however, the Committee remains concerned that FTEE levels across the board are actually below the fiscal year 2002 level. The Committee recommends an additional $17 million to sustain employment and other critical operational process improvements within VBA's major business lines: compensation, pensions, education,

housing, vocational rehabilitation and employment, insurance and burial.

Regional Office Staffing. – The Committee is concerned about the apparent lack of a long-term strategy for addressing the claims needs of veterans served by poorly performing regional offices. The Committee expects that VA will clearly articulate a plan for addressing this critical problem and will effectively use any funding for additional personnel to improve performance. The Committee also expects that VA would closely monitor the quality and productivity of any regional office that receives additional funding or staff.

Homeless Veterans Coordinators. – Public Law 107-95 requires the Secretary to ensure that there is at least one full-time employee assigned to oversee and coordinate homeless veterans programs at each of the 20 regional offices that the Secretary determines have the largest homeless populations within the regions of VBA. The Committee understands that, although the offices have been designated and personnel nominally assigned as coordinators, some of these employees have multiple responsibilities and are not able to devote full-time efforts to addressing the needs of homeless veterans. The Committee expects that employees will be assigned to perform the oversight and coordination activities mandated by Public Law 107-95 on a full-time basis and that general operating expense funding for fiscal year 2004 will be used to support the positions.

National Cemetery Administration

The President is requesting $156 million for (1) National Cemetery Administration (NCA) operation and maintenance of 124 national cemeteries and 33 soldiers' and sailors' lots in private or municipal cemeteries, monument sites and confederate cemeteries, and (2) VBA adjudication of veterans' death benefits. The President's budget request supports 1,588 FTEE in NCA – an increase of 69 FTEE from the Fiscal Year 2003 request – and 177 FTEE in VBA, an increase of two FTEE over last year's request.

The President is requesting $108.9 million to develop new national cemeteries, create additional gravesites at existing national cemeteries, and establish/expand state veterans cemeteries. The funds would be used to develop and/or expand cemeteries in the following locations:

- Detroit area, phase one development of a new national cemetery;
- Ft. Snelling, Minnesota, expansion of and improvements to national cemetery; and
- Barrancas National Cemetery, Florida, expansion of and improvements to national cemetery.

The President's request does not provide funding for 928 full-scale cemetery restoration and repair projects, estimated to cost $279 million, or funding for development of new national cemeteries beyond those currently in development in Pittsburgh, Sacramento, Southern Florida, and Atlanta. A study mandated by Public Law 106-117 of future burial needs determined that based upon 1990 census data, NCA would need to develop 31 new cemeteries by 2020 to meet the burial needs of veterans and their survivors. NCA is currently reevaluating that recommendation with recently available data from the 2000 census.

The National Cemetery Administration (NCA) maintains almost 2.5 million gravesites at 124 national cemeteries in 39 states, the District of Columbia and Puerto Rico. Of these, 61 have available, unassigned gravesites for burial of both casketed and cremated remains; 26 will only accept cremated remains and the remains of family members for interment in the same gravesite as a previously deceased family member; and 33 are closed to new interments, but may accommodate family members in the same gravesite as a previously deceased family member.

Occupied graves maintained by NCA are projected to increase from 2,380,500 in fiscal year 2000 to over 2,998,100 in 2008. VA is continuing to develop new cemeteries in areas not presently served by NCA: Atlanta, Georgia; Detroit, Michigan; Fort Sill, Oklahoma; Miami, Florida; Pittsburgh, Pennsylvania; and Sacramento, California. However, an independent study – mandated in Public Law 106-117 – of veterans' burial needs based on VA planning guidelines found that VA should establish 31 additional cemeteries through 2020 to provide service to 90 percent of veterans within 75 miles of their homes. This assumed a veteran population threshold of 170,000. This study was based upon data from the 1990 census. The Committee understands that the report is being updated to reflect 2000 census data. Upon completion of that update, the Committee may direct the Secretary to begin the planning phase for the construction of seven new veterans' cemeteries in those areas, with a veteran population threshold of 150,000, that are deemed most in need between 2005 and 2020.

The Committee recommends a five-year, $300 million restoration and improvements project at existing cemeteries.

Board of Veterans' Appeals

The President is requesting $50.4 million and 448 FTEE to support its operations at the Board of Veterans' Appeals (the Board). In fiscal year 2002, the Board received 28,158 appeals and decided 17,231 appeals: 27.7 percent were granted in the veterans' favor, 19.3 percent were remanded to a regional office for further development, and 49.9 percent were denied. The Committee recognizes that due to a number of factors, including the large number of remands following enactment of legislation mandating the VA's "duty to assist" claimants, the number of appeals decided during fiscal year 2002 was unusually low. Based upon new appeals filed during 2002, the Committee expects that the number of decisions will return to more historic levels (between 30,000 and 40,000), assuming adequate staffing at the Board during future fiscal years.

During the past year, the Board has begun to assist in developing some claims rather than remanding all of them to the regional offices. The Board has converted 31 attorney positions to support staff positions to staff the Evidence Development Unit. It appears the loss of these attorneys has had a significant impact on the Board's capacity to produce final decisions in a timely manner. According to the Fiscal Year 2002 Report of the Board Chairman and the Administration's budget request, without additional FTEE, the Board will not be able to keep pace with the additional appeals it receives. With current staffing and a 25 percent productivity increase projected in the budget request, the Board is expected to develop a backlog of 6,000 to 8,000 appeals per year. However, no additional funding has been requested. The Committee expects that the Board will manage its operations to fulfill its primary function of deciding administrative appeals without developing an unacceptable backlog.

DEPARTMENT OF LABOR

Veterans' Employment and Training Service

The Jobs for Veterans Act, Public Law 107-288, redesigned the nationwide delivery system of veterans' employment and training services based on themes of incentives, results, accountability, and flexibility. In early December 2002, the Department of Labor (DOL) established a comprehensive work group of state and federal representatives to draft a broad plan for implementing the new law. The Committee commends this prompt action.

The states reported an average Entered Employment Rate (percentage who register for work with the Job Service or a One-Stop Career Center and gain employment) for veterans for the first three quarters for fiscal year 2002 (October 1, 2001 – June 30, 2002) of 41 percent. For fiscal years 1999, 2000, and 2001, the Entered Employment Rate for veterans averaged about 30 percent. The Committee views the improvement in Entered Employment Rate as a promising start.

The most recent DOL-published unemployment rate data are as follows:

Average 2002 Unemployment Rates for Male and Female Veterans

Age	**Male Veterans**	**Female Veterans**
All Ages	4.7%	5.0%
20-24	10.8%	13.3%
25-34	5.7%	5.5%
35-44	5.3%	5.0%
45-54	4.6%	3.4%
55-64	4.2%	2.5%

Average 2002 Unemployment Rates for Black and Hispanic Veterans

Male/Female Black/Hispanic	**All Ages**	**20-24**
Black Male	7.0%	17%
Black Female	6.6%	23.9%
Hispanic Male	4.7%	8.7%
Hispanic Female	9.9%	21.6%

Further, according to the Bureau of Labor Statistics, 50.7 percent of all disabled male veterans were in the labor force in August 2001. The unemployment rate for disabled male veterans was 4.4 percent. The unemployment rate for "special" disabled male veterans (rated at least 30 percent disabled by VA) was 8.5 percent. The Committee notes Public Law 107-288 authorizes the Secretary of Labor to create a "weighted" placement system that provides greater job placement credit for harder-to-place veterans, such as those who are disabled or have other unique needs.

The Administration is requesting $219,993,000 for VETS for fiscal year 2004: $162.415 million for state grants for Disabled Veterans Outreach Program Specialists and Local Veterans Employment Representatives, $29.028 million for federal program administration, $2 million for the National Veterans' Employment and Training Services Institute (NVESTI), $19 million for the Homeless Veterans' Reintegration Program (HVRP), and $7.55 million for the Veterans Workforce Investment Program. The fiscal year 2003 appropriation for VETS is $214,212,000. The Committee recommends an additional $1 million for the NVESTI. Congress authorized funding of $50 million for HVRP in Public Law 106-117.

The Committee believes that the HVRP is one of the most cost effective job placement programs in the Federal government. During fiscal year 2002, DOL competitively awarded 102 grants: 43 to non-profit organizations, 11 to faith-based organizations, and the remainder to state and local agencies. These grants resulted in the enrollment of 12,142 homeless veterans in the program. Of those enrolled, 6,605 successfully entered employment, despite in many cases having to overcome major obstacles to being employable. The Committee accordingly recommends an additional $31 million for HVRP.

LEGISLATION THE COMMITTEE MAY REPORT WITH DIRECT SPENDING IMPLICATIONS

Montgomery GI Bill. – The current Montgomery GI Bill (MGIB)-Active Duty basic benefit is $900 per month, effective October 1, 2002. This benefit increases to $985 per month effective October 1, 2003, per Public Law 107-103, enacted December 27, 2001. The Committee recommends an increase in the MGIB to $1,200 per month effective October 1, 2004. Against the current baseline, the Committee estimates this measure would cost about $405 million in 2004, and $2.63 billion over five years. This increase would represent an interim step toward implementing the bipartisan Servicemembers and Veterans Transition Assistance Commission recommendation for an MGIB that pays tuition, fees, and a monthly subsistence allowance, thus allowing veterans to pursue enrollment in any educational institution in America limited only by their aspirations, abilities, and initiative.

Based on data from the College Board's "Trends in College Pricing for the 2002-2003 Academic Year," the Committee concludes that the current monthly basic MGIB benefit would need to be $1,496 per month for a veteran-student to be able to pay the average tuition and expenses as a commuter student at a four-year public college for academic year 2002-2003. The College Board's 2002-2003 academic year statistics reflect that average annual tuition and fees, books and supplies, room and board, transportation and other expenses for attending a four-year public college amount to $13,463 for a commuter student and $12,841 for a student who lives on campus. Four-year private institutions cost $27,695 and $27,677, respectively. With the current basic MGIB annual benefit of $8,100, however, a veteran is expected to pay tuition, fees, room and board, and other living expenses during the academic year. The disparity between these ever increasing costs and a veteran's ability to pay for them using the MGIB benefits seems clear.

The Committee also recommends repeal of the current $1,200 pay reduction under the MGIB-Active Duty program. The Committee estimates the cost of the repeal would be $227

million in the first year and $1.18 billion over five years. This repeal was a recommendation of the Congressional Commission on Servicemembers and Veterans Transition Assistance. The Committee notes the MGIB is the only form of federal student financial aid in which the student is required to furnish $1,200 in cash "up-front" to establish eligibility for the program.

Congress has not updated the on-the-job training and apprenticeship programs under the MGIB and other VA educational assistance programs essentially since World War II. The Committee may report legislation to update this program to reflect on-job training and apprenticeship in business and industry today. Such legislation may incur limited costs against the baseline of $3 million or less per year.

Option of $50 monthly MGIB pay reduction. – A servicemember's pay is reduced $100 per month for the first 12 months of active-duty service to establish eligibility for the MGIB. The Committee views the $1,200 as a burdensome fee that discourages veteran participation in the program. No other federal education program charges such a fee. The Committee recommends legislation to give servicemembers the option of a pay reduction of $100 per month for 12 months or $50 per month for 24 months. The Committee estimates the cost to be $101 million in 2004, and $100 million over five years.

Access to Entrepreneurship. – The Committee recommends legislation to help veterans start small businesses. The legislation would: (1) allow veterans to use VA education benefits to enroll in non-credit small business courses sponsored by Small Business Development Centers and others, (2) liberalize current law language to make it easier for graduates of a VA vocational rehabilitation program to go directly into business for themselves, and (3) make revisions to current law to allow disabled veterans a greater opportunity to compete for contracts with the Federal government. The Committee estimates costs of $2 million or less per year.

Dependency and Indemnity Compensation for Surviving Spouses Who Remarry after Age 55. – Dependency and Indemnity Compensation (DIC) provides a partial substitute for the economic loss suffered by the survivors upon the service-connected death of a veteran. For a survivor to be eligible, the veteran must have died during military service, from a service-connected disability, or have had a service-connected disability that was rated 100 percent for 10 years prior to death from a non-service-connected condition. DIC terminates upon the remarriage of a surviving spouse, although benefits may be restored in the event that the subsequent remarriage ends in death or divorce. DIC is the only federal annuity program that does not allow a surviving spouse who is receiving compensation to remarry at an older age and retain the annuity. Public Law 107-330 provided that a surviving spouse, upon remarriage after attaining age 55, would retain health insurance under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). The Committee recommends legislation to allow a surviving spouse who remarries after age 55 to retain DIC, education, and home loan benefits. In 2002, the Congressional Budget Office estimated the cost of this eligibility change to be $38 million in 2003, $368 million over five years, and $779 million over ten years.

Vocational Training for Non-Service-Connected Pension Recipients under Age 50. – The non-service-connected disability pension program provides financial help to more than 348,000 low-income veterans. To be eligible, veterans must have served on active

duty for at least 90 days including at least one day of wartime service, and be totally and permanently disabled for employment purposes as a result of disability not related to their military service, or over age 65. To ensure the availability of vocational training to newly eligible VA non-service-connected pension recipients age 45 or younger, the Committee recommends legislation to reinstate a pilot program that expired in December 1995. The program would afford pension recipients the opportunity to receive training, along with a stipend, in order to return to the job market rather than requiring these veterans to rely solely on the VA pension program for their financial well being. The Committee estimates the cost to be $1 million in the first year and $9 million over 5 years.

Accrued Benefits for Veterans' Survivors. – Current law restricts a surviving spouse to receiving no more than two years of accrued benefits if a veteran dies while a claim for VA periodic monetary benefits (other than insurance and servicemen's indemnity) is being processed. VA is making efforts to lower claims processing times, but it can sometimes take more than two years to correctly determine and adjudicate a claim for disability compensation or non-service-connected pension benefits. The Committee recommends legislation to repeal the two-year limitation so that the veteran's survivor may receive the full amount of the award and not be penalized if VA does not process claims in a timely manner. The Committee estimates the cost to be $1 million per year.

Special Compensation for Former Prisoners of War. – The Committee recommends legislation to establish a three-tiered special monthly pension to former prisoners of war, to be based upon the length of captivity. Those who were detained 30-120 days would receive $150 per month, those detained 121-540 days would receive $300 per month, and those detained 540 or more days would receive $450 per month. In 2002, the Congressional Budget Office estimated a direct spending increase of $24 million in 2003, $345 million over five years, and $634 million over ten years for special compensation to former prisoners of war. The Committee also recommends legislation to extend VA dental benefits to all former prisoners of war, regardless of their length of captivity. The Congressional Budget Office estimates this program expansion would cost less than $500,000.

National Cemetery Administration. – As discussed above, the Committee may direct the Secretary to begin the planning phase for the construction of seven new veterans' cemeteries in those areas, with a veteran population threshold of 150,000, that are deemed most in need between 2005 and 2020. In addition, the Committee recommends a five-year, $300 million restoration and improvements project at existing cemeteries to ensure that national cemeteries are dignified and respectful settings.

Increase Auto Allowance and Specially Adapted Housing Allowance for Severely Disabled Veterans. – VA is authorized to provide a one-time reimbursement to severely disabled veterans of $9,000 for the cost of an automobile. According to the American Association of Motor Vehicle Administrators, the average cost of a new automobile was estimated to be $21,605 in 2001. The Committee recommends legislation to increase the auto allowance to $11,000. VA also provides a grant to offset the cost of modifying a home to accommodate a veteran's disabilities. The Committee also recommends legislation to increase the grant for specially adapted housing for severely disabled veterans to $50,000 and for less severely disabled veterans to $10,000. The Committee estimates combining these two proposals to cost $6

million in 2004, $34 million over 5 years, and $74 million over 10 years.

Vendee Loans. – The Committee opposes VA's January 23, 2003, decision to administratively terminate the vendee loan program. When a purchaser agrees to buy a foreclosed VA home, VA often offers to finance the sale by establishing a vendee loan to encourage the prompt sale of the home. Vendee loans are made at market interest rates and often require a down payment. Borrowers are assessed a 2.25 percent funding fee that is paid in cash.

The Committee views vendee loans as an important tool to obtain a higher return on property sales, which reduces the overall cost of program operations. VA makes, and subsequently sells, $800 million to $1.2 billion in such loans each fiscal year. There is an ample body of empirical data indicating that offering vendee financing is cost effective. In March 2002, Booz, Allen, and Hamilton, Inc., independently analyzed the cost effectiveness of vendee loan financing. Their report indicated a savings to the government of $16 million in fiscal year 1999 due to vendee financing. The Committee believes the vendee loan program is based on sound business principles and recommends legislation to reinstate the program.

Guaranteed Health Funding. – Because VA health care discretionary appropriations have not kept pace with the needs of veterans enrolled in the VA health care system, H.R. 5250 was introduced in the 107th Congress to establish a funding formula to guarantee sufficient annual funding to meet the medical care needs of these veterans. The bill was intended to stabilize VA's health care financing and promote more efficient use of funds.

The Committee expects to consider similar legislation in the 108th Congress and recommends to the Committee on the Budget that it convert the veterans health care account from discretionary to mandatory funding. The Committee believes the conversion would be essentially budget neutral because the increase in mandatory funding would be offset by an decrease in current discretionary appropriations for veterans health care. The continuing health care of veterans would be funded through a new financing system similar to the financing systems used for the military TRICARE for Life program, the Medicare program and the Federal Employees Health Benefits Program. In none of these programs has the funding formula itself been the source of increased costs. Veterans deserve a health care program with an equally reliable funding mechanism.